| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155166 | A. BUILDING _____ B. WING _____ | C 01/16/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VALPARAISO CARE AND REHABILITATION CENTER | 606 WALL ST VALPARAISO, IN 46383 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS | F 000 | | |

This visit was for the investigations of Complaint IN00121671, Complaint IN 00121365, and Complaint IN00121356.

This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN0012997 and Complaint IN00114283.

Complaint IN00121671 - Substantiated. No deficiencies related to the allegations are cited.
Complaint IN00121365 - Unsubstantiated due to lack of evidence.
Complaint IN00121356 - Unsubstantiated due to lack of evidence.

Survey dates: January 14, 15, and 16, 2013

Facility number : 000083
Provider number: 155166
AIM number: 100289670

Survey Team:
Linn Mackey RN, TC
Shelly Reed RN

Census bed type:
SNF/NF: 154
Total: 154

Census Payor type:
Medicare: 16
Medicaid: 124
Other: 14
Total: 154

Sample: 11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **VALPARAISO CARE AND REHABILITATION CENTER** | **606 WALL ST VALPARAISO, IN 46383** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br>Valparaiso Care and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00121671, IN00121365, and IN00121356. | F 000 | | |